maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Camzyos

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the medication being prescribed by a cardiologist? [If no, no further questions.]	Yes	No
2	What is the diagnosis or indication? [] Obstructive Hypertrophic Cardiomyopathy (If checked, go to 3) [] Other (If checked, no further questions)		
3	Is the patient currently receiving the requested medication?	Yes	No

If you have any questions, call: 1-888-258-8250

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	[If no, skip to question 17.]		
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 17.]	Yes	No
5	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 12.]	Yes	No
6	Has the patient been established on therapy for at least 6 months? [Note: A patient who has received less than 6 months of therapy or who is restarting therapy is reviewed under initial therapy.] [If no, skip to question 17.]	Yes	No
7	Does the patient have a current left ventricular ejection fraction of greater than or equal to 50 percent? [If no, no further questions.]	Yes	No
8	Has the patient had two left ventricular ejection fractions of less than 50 percent while on a dose of 2.5 mg daily? [If yes, no further questions.]	Yes	No
9	Has the patient experienced a beneficial clinical response when assessed by at least one objective measure? [Note: Examples include improved peak oxygen consumption/mixed venous oxygen tension, decreases in left ventricular outflow tract gradient, reductions in N-terminal pro-B-type natriuretic peptide levels, decreased high-sensitivity cardiac troponin I levels, reduced ventricular mass index, and/or a reduction in maximum left atrial volume index.] [If yes, skip to question 11.]	Yes	No
10	Has the patient experienced stabilization or improvement in at least one symptom related to obstructive hypertrophic cardiomyopathy? [Note: Examples of symptoms include shortness of breath, chest pain, lightheadedness, fainting, fatigue, ability to perform physical exercise, and/or favorable changes in the Kansas City Cardiomyopathy Questionnaire-23 (KCCQ-23) Clinical Summary Score (CSS) or Hypertrophic Cardiomyopathy Symptom Questionnaire (HCMSQ) Shortness of Breath domain scores.] [If no, no further questions.]	Yes	No
11	Has the patient been adherent with the medication and is enrolled in Camzyos REMS Program? [No further questions.]	Yes	No
12	Does the patient have a current left ventricular ejection fraction of greater than or	Yes	No

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	equal to 50 percent? [If no, no further questions.]		
13	Has the patient had two left ventricular ejection fractions of less than 50 percent while on a dose of 2.5 mg daily? [If yes, no further questions.]	Yes	No
14	Has the patient experienced a beneficial clinical response when assessed by at least one objective measure? [Note: Examples include improved peak oxygen consumption/mixed venous oxygen tension, decreases in left ventricular outflow tract gradient, reductions in N-terminal pro-B-type natriuretic peptide levels, decreased high-sensitivity cardiac troponin I levels, reduced ventricular mass index, and/or a reduction in maximum left atrial volume index.] [If yes, skip to question 16.]	Yes	No
15	Has the patient experienced stabilization or improvement in at least one symptom related to obstructive hypertrophic cardiomyopathy? [Note: Examples of symptoms include shortness of breath, chest pain, lightheadedness, fainting, fatigue, ability to perform physical exercise, and/or favorable changes in the Kansas City Cardiomyopathy Questionnaire-23 (KCCQ-23) Clinical Summary Score (CSS) or Hypertrophic Cardiomyopathy Symptom Questionnaire (HCMSQ) Shortness of Breath domain scores.] [If no, no further questions.]	Yes	No
16	Has the patient been adherent with the medication and is enrolled in Camzyos REMS Program? [If no, no further questions.]	Yes	No
17	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
18	Does the patient have at least one symptom associated with obstructive hypertrophic cardiomyopathy? [Note: Examples of symptoms include shortness of breath, chest pain, lightheadedness, fainting, fatigue, and reduced ability to perform physical exercise.] [If no, no further questions.]	Yes	No
19	Does the patient have New York Heart Association Class II or III symptoms of heart failure? [Note: Class II signifies mild symptoms with moderate physical activity and some exercise limitations whereas Class III denotes noticeable symptoms with minimal physical activity and patients are only comfortable at rest.] [If no, no further questions.]	Yes	No
20	Does the patient have maximal left ventricular wall thickness greater than or equal to 15 mm?	Yes	No

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	[If yes, skip to question 22.]		
21	Does the patient have familial hypertrophic cardiomyopathy with a maximal left ventricular wall thickness greater than or equal to 13 mm? [If no, no further questions.]	Yes	No
22	Does the patient have a peak left ventricular outflow tract gradient greater than or equal to 50 mmHg (at rest or after provocation [Valsalva maneuver or post exercise])? [If no, no further questions.]	Yes	No
23	Does the patient have a left ventricular ejection fraction with a lower range greater than or equal to 55 percent? [If no, no further questions.]	Yes	No
24	What is the patient's gender? [] Male (males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity) (If checked, go to 27) [] Female (females are defined as individuals with the biological traits of a female, regardless of the individual's gender identity or gender expression) (If checked, go to 25) [] Other/unknown (If checked, no further questions)		
25	Is the patient a woman of childbearing potential? [If no, skip to question 27.]	Yes	No
26	Is there a documented contraceptive plan and negative pregnancy test? [If no, no further questions.]	Yes	No
27	Is there verification that the prescriber and patient is enrolled in Camzyos REMS Program? [If no, no further questions.]	Yes	No
28	Has documentation been submitted to confirm that patient has an intolerance, contraindication to, or failed treatment up to the maximally indicated dose with ALL of the following: A) Non-vasodilating beta-blocker (such as metoprolol, bisoprolol, propranolol), B) Non-dihydropyridine calcium channel blocker (such as verapamil, diltiazem), C) Combination of beta-blocker and calcium channel blocker, and D) Disopyramide? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
29	Does the patient have any of the following: A) Amyloidosis, B) Fabry Disease, or C) Noonan Syndrome with Left Ventricular Hypertrophy? [If yes, no further questions.]	Yes	No
30	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication?	Yes	No

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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